Indiana Telehealth Network
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Quarterly Data Report Requirements

APPENDIX D – Pages 73-75 of Federal Communications Commission FCC 07-198

1. Project Contact and Coordination Information

a. Identify the project leader(s) and respective business affiliations.

- Project Coordinator - Don Kelso, Executive Director, Indiana Rural Health Association, dkelso@indianarha.org, see bio in Appendix A.
- Associate Project Coordinator – Becky Sanders, FCC Pilot Program Coordinator, Indiana Rural Health Association, bsanders@indianarha.org, see bio in Appendix A.

b. Provide a complete address for postal delivery and the telephone, fax, and e-mail address for the responsible administrative official.

- ***Effective October 30, 2009, the IRHA office moved from 1024 South 6th Street, Suite 202, Terre Haute, IN 47807 to 2901 Ohio Blvd., Suite 110, Terre Haute, IN 47803***
- Don Kelso
- Executive Director
- Indiana Rural Health Association
- 2901 Ohio Blvd., Suite 110
- Terre Haute, IN 47803
- Phone: 812-478-3919, ext. 224
- Fax: 812-232-8602
- dkelso@indianarha.org

c. Identify the organization that is legally and financially responsible for the conduct of activities supported by the award.

- The Indiana Rural Health Association (IRHA)
    - The mission of the IRHA is to enhance the health and well-being of rural populations in Indiana through leadership, education, advocacy, and collaboration. The IRHA is a not-for-profit corporation developed for the purpose of improving the health of all Indiana citizens in rural settings. The Indiana Rural Health Association is a member-driven organization composed of a diverse membership. The Association is committed to recruiting a diverse, grassroots membership with intrinsic strengths important to the task of providing meaningful forums. The forums provide opportunities for assessing the strengths and

weaknesses of the health care systems; identifying needs/problems within the rural settings; and assessing and developing leadership resources. The IRHA was organized in 1997. The strength of the organization is through the present diverse membership and the founding organizers who are committed to impacting the health of citizens through the identification of rural health issues and through advocacy roles in both the public and private sectors. The Board of Directors is committed to recruiting a large and diverse membership who can provide input on an even wider perspective. The Association hosts an Annual Conference in June of each year. The Conference programs are designed to speak to a wide and diverse audience with varied topics and issues. Communication lines have been formed with State government, health care delivery systems, local governments, rural citizens, business, economic development offices, and rural development offices.

d. Explain how project is being coordinated throughout the state or region.

- Since the announcement of the grant awards in November, 2007, we have held periodic meetings of our Advisory Board, made up of the Plan Co-Applicants and the Indiana Office of Community and Rural Affairs. We have committees composed of representatives from Indiana's health community and telecommunications industry.
- We conducted an RFI during the summer of 2008 to assist us in writing the RFP. We received 16 responses to our RFI at the end of August 2008.
- At the September 2008 IRHA Board Retreat, the governing board of IRHA voted to make the Advisory Board a subcommittee of the governing board. Therefore, the entity previously known as the FCC Pilot Project Advisory Board will henceforth be known as the FCC Pilot Project Steering Committee, or "Steering Committee".
- We have held several meetings for our healthcare participants and interested bidders to garner interest and support for this project.
- The Indiana Office of Technology assisted us with the creation of the Indiana Telehealth Network RFP #00 (RFP).
- In June 2009, we held a joint meeting with representatives from our healthcare participants and interested bidders. The purpose of this meeting was to lay the groundwork for the RFP, which was released on June 30, 2009. In addition to the posting of the RFP on the USAC website, we worked with our contacts at the Indiana Utilities Regulatory Commission to ensure that all telecommunications providers authorized to provide telecommunications services in the state of Indiana were aware of the RFP.
- Responses to our RFP were due September 2, 2009. We received 14 responses to the RFP. The Indiana Office of Technology has continued to assist us with the evaluation and scoring of the RFP responses.
- During the 4th quarter of 2009, we discussed the RFP responses with the individual bidders, the participating hospitals, and our Steering Committee. All responses were scored, based on an objective scoring system, by volunteers from the hospitals listed as participants in the RFP. Based on that scoring, as well as input from the hospitals, 13 of

the 14 vendors who responded to our RFP were invited to conduct site visits at the hospitals to assist the vendors in the calculations for their best and final offers, which were due on January 14, 2010.

- We received all 13 Best and Final offers, as requested on January, 14, 2010. Those bids were compiled, analyzed, and presented to our full Steering Committee during the first week of February.
- Based on the recommendations of our Steering Committee, the best and final offers were sent out to our participating hospitals at the beginning of February. Hospitals were asked to sign a letter of intent, indicating their intent to enter into contract negotiations with their winning vendor. The letter of intent also included information regarding their interest in Phase I (construction and/or internet access) or Phase II (dedicated transport to a common meet point in Indianapolis), as well as the level of bandwidth they desired (10mbps, 50 mbps, 100 mbps, or 1 gbps).
- Formal letters of congratulations were sent to the winning vendors at the beginning of March. Contract negotiations and kick-off meetings began immediately.
- We had hoped to have contracts signed by the end of March, but contract negotiations have taken longer than we anticipated.
- We now anticipate contracts to be signed by the end of April. Vendor packages and additional information required by USAC will be compiled and posted as soon as possible. Because each healthcare participant is responsible for their own 15% match and recurring connection charges, we have asked the vendors to present individual contracts with individual pricing to each participating hospital. Common contract templates are being used by each vendor.
- As of July 28, 2010, we have submitted seven (7) 466-A packages to USAC for approval, representing six (6) vendors and nine (9) hospitals. We have received Funding Commitment Letters for five (5) hospitals. Construction and/or equipment upgrades have started at the locations where FCLs have been received.
- As of September 30, 2010, we have submitted a total of eight (8) 466-A packages to USAC for approval, representing all eight (8) of our vendors and ten (10) hospitals. We have received funding commitment letters for ten (10) hospitals in the amount of around $900,000.
- By the end of 2010, we expect construction and/or installation of upgraded equipment to be completed at the majority of these locations. The Indiana Telehealth Network gateway to the public internet went live mid-October 2010.

2. Identify all health care facilities included in the network.

a. Provide address (including county), zip code, Rural Urban Commuting Area (RUCA) code (including primary and secondary), six-digit census tract, and phone number for each health care facility participating in the network.
b. For each participating institution, indicate whether it is:

i. Public or non-public;
ii. Not-for-profit or for-profit;
iii. An eligible health care provider or ineligible health-care provider with an explanation of why the health care facility is eligible under section 254 of the 1996 Act and the Commission's rules or a description of the type of ineligible health care provider entity.

- The following table contains the data requested above. The census tract codes referenced below were obtained from http://www.ffiec.gov/Geocode/default.aspx. The RUCA codes referenced below were obtained from http://depts.washington.edu/uwruca/ruca1/rucas.html.

- This list includes all participants listed in our RFP#00.

- This following list has been updated as of December 31, 2010. Several hospitals have opted out due to existing contracts, lack of 15% match dollars, and/or other reasons. Hospitals that have opted-out are shaded in gray.

Critical Access Hospitals (Participants 1-35)				
	Hospital Name and Address	**County**	**Public/Profit**	**RUCA/Census**
1	***Adams Memorial Hospital***	*ADAMS*	*Public*	*Census Tract: 0303.00*
	1100 Mercer Ave.			*County Code: 001*
	Decatur, IN 46733		***Eligible provider?***	*RUCA Primary: 7*
	260-724-2145		*Yes, not-for-profit hospital*	*RUCA Secondary: 7.3*
2	**Bedford Regional Medical Center**	LAWRENCE	Private	Census Tract: 9508.00
	2900 W. 16th Street			County Code: 093
	Bedford, IN 47421		**Eligible provider?**	RUCA Primary: 4
	812-275-1390		Yes, not-for-profit hospital	RUCA Secondary: 4.0
3	***Blackford Community Hospital***	*BLACKFORD*	*Private*	*Census Tract: 9754.00*
	410 Pilgrim Blvd.			*County Code: 009*
	Hartford City, IN 47348		***Eligible provider?***	*RUCA Primary: 7*
	765-331-2101		*Yes, not-for-profit hospital*	*RUCA Secondary: 7.4*

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	Hospital Name and Address	**County**	**Public/Profit**	**RUCA/Census**
4	***Bloomington Hospital of Orange County***	*ORANGE*	*Private*	*Census Tract: 9514.00*
	642 West Hospital Road			*County Code: 117*
	PO Box 499		***Eligible provider?***	*RUCA Primary: 9*
	Paoli, IN 47454		*Yes, not-for-profit hospital*	*RUCA Secondary: 9.0*
	812-723-7410			
5	***Cameron Memorial Community Hospital***	*STEUBEN*	*Private*	*Census Tract: 9714.00*
	416 E. Maumee Street			*County Code: 151*
	Angola, IN 46703		***Eligible provider?***	*RUCA Primary: 7*
	260-665-2141		*Yes, not-for-profit hospital*	*RUCA Secondary: 7.0*
6	**Community Hospital of Bremen**	MARSHALL	Private	Census Tract: 0201.01
	1020 High Road PO Box 8			County Code: 099
	Bremen, IN 46506		**Eligible provider?**	RUCA Primary: 8
	574-546-8000		Yes, not-for-profit hospital	RUCA Secondary: 8.3
7	**Decatur County Memorial Hospital**	DECATUR	Public	Census Tract: 9693.00
	720 N. Lincoln Street			County Code: 031
	Greensburg, IN 47240		**Eligible provider?**	RUCA Primary: 7
	812-663-1170		Yes, not-for-profit hospital	RUCA Secondary: 7.0
8	***Dukes Memorial Hospital***	*MIAMI*	*Private*	*Census Tract: 9522.00*
	275 West 12th St.			*County Code: 103*
	Peru, IN 46970		***Eligible provider?***	*RUCA Primary: 4*
	765-475-2300		*Yes, dedicated*	*RUCA Secondary: 4.0*

			ER of rural for-profit hospital	
	Hospital Name and Address	**County**	**Public/Profit**	**RUCA/Census**
9	***Dunn Memorial Hospital***	*LAWRENCE*	*Private*	*Census Tract: 9511.00*
	1600 23rd Street			*County Code: 093*
	Bedford, IN 47421		***Eligible provider?***	*RUCA Primary: 4*
	812-276-1210		*Yes, not-for-profit hospital*	*RUCA Secondary: 4.0*
10	***Gibson General Hospital***	*GIBSON*	*Private*	*Census Tract: 0505.00*
	1808 Sherman Drive			*County Code: 051*
	Princeton, IN 47670		***Eligible provider?***	*RUCA Primary: 7*
	812-385-9221		*Yes, not-for-profit hospital*	*RUCA Secondary: 7.3*
11	**Greene County General Hospital**	GREENE	Public	Census Tract: 9549.00
	Rural Route #1, Box 1000			County Code: 055
	Lone Tree Road		**Eligible provider?**	RUCA Primary: 7
	Linton, IN 47441		Yes, not-for-profit hospital	RUCA Secondary: 7.3
	812-847-5212			
12	***Harrison County Hospital***	*HARRISON*	*Public*	*Census Tract: 0603.00*
	1141 Hospital Drive			*County Code: 061*
	Corydon, IN 47112		***Eligible provider?***	*RUCA Primary: 7*
	812-738-4251		*Yes, not-for-profit hospital*	*RUCA Secondary: 7.3*
13	**Jasper County Hospital**	JASPER	Public	Census Tract: 9912.00
	1104 E. Grace St.			County Code: 073
	Rensselaer, IN 47978		**Eligible provider?**	RUCA Primary: 7
	219-866-2020		Yes, not-for-profit hospital	RUCA Secondary: 7.0

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	Hospital Name and Address	County	Public/Profit	RUCA/Census
14	**Jay County Hospital**	JAY	Public	Census Tract: 9631.00
	500 W. Votaw St.			County Code: 075
	Portland, IN 47371		**Eligible provider?**	RUCA Primary: 7
	260-726-7131		Yes, not-for-profit hospital	RUCA Secondary: 7.0
15	**Margaret Mary's Community Hospital**	FRANKLIN	Private	Census Tract: 9601.00
	321 Mitchell Ave.			County Code: 047
	Batesville, IN 47006		**Eligible provider?**	RUCA Primary: 7
	812-933-5049		Yes, not-for-profit hospital	RUCA Secondary: 7.0
16	***Parkview LaGrange Hospital***	*LAGRANGE*	*Private*	*Census Tract: 9702.00*
	207 North Townline Road			*County Code: 087*
	LaGrange, IN 46761		***Eligible provider?***	*RUCA Primary: 10*
	260-463-9002		*Yes, not-for-profit hospital*	*RUCA Secondary: 10.4*
17	**Perry County Memorial Hospital**	PERRY	Public	Census Tract: 9525.00
	One Hospital Road			County Code: 123
	Tell City, IN 47586		**Eligible provider?**	RUCA Primary: 7
	812-547-0170		Yes, not-for-profit hospital	RUCA Secondary: 7.0
18	**Pulaski Memorial Hospital**	PULASKI	Public	Census Tract: 9590.00
	616 E. 13th St.			County Code: 131
	P.O. Box 279		**Eligible provider?**	RUCA Primary: 10
	Winamac, IN 46996		Yes, not-for-profit hospital	RUCA Secondary: 10.0
	574-946-2160			

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	Hospital Name and Address	County	Public/Profit	RUCA/Census
19	**Putnam County Hospital**	PUTNAM	Public	Census Tract: 9563.00
	1542 S. Bloomington St.			County Code: 133
	Greencastle, IN 46135		**Eligible provider?**	RUCA Primary: 7
	765-655-2620		Yes, not-for-profit hospital	RUCA Secondary: 7.3
20	**Rush Memorial Hospital**	RUSH	Public	Census Tract: 9744.00
	1300 N. Main St.			County Code: 139
	PO Box 608		**Eligible provider?**	RUCA Primary: 7
	Rushville, IN 46173		Yes, not-for-profit hospital	RUCA Secondary: 7.3
	765-932-7513			
21	***Scott County Memorial Hospital***	*SCOTT*	*Public*	*Census Tract: 9670*
	1451 North Gardner Street			*County Code: 143*
	Scottsburg, IN 47170		***Eligible provider?***	*RUCA Primary: 7*
	812-752-8500		*Yes, not-for-profit hospital*	*RUCA Secondary: 7.3*
22	**St. Mary's Warrick Hospital**	WARRICK	Private	Census Tract: 0306.00
	1116 Millis Avenue			County Code: 173
	Boonville, IN 47601		**Eligible provider?**	RUCA Primary: 7
	812-897-7112		Yes, not-for-profit hospital	RUCA Secondary: 7.1
23	***St. Vincent Clay Hospital***	*CLAY*	*Private*	*Census Tract: 0402.00*
	1206 East National Avenue			*County Code: 021*
	PO Box 489		***Eligible provider?***	*RUCA Primary: 7*
	Brazil, IN 47834		*Yes, not-for-profit hospital*	*RUCA Secondary: 7.3*
	812-442-2602			

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	Hospital Name and Address	County	Public/Profit	RUCA/Census
24	***St. Vincent Frankfort Hospital***	*CLINTON*	*Private*	*Census Tract: 9508.00*
	1300 South Jackson Street			*County Code: 023*
	Frankfort, IN 46041		***Eligible provider?***	*RUCA Primary: 4*
	765-656-3139		*Yes, not-for-profit hospital*	*RUCA Secondary: 4.0*
25	***St. Vincent Jennings Hospital***	*JENNINGS*	*Private*	*Census Tract: 9604.00*
	301 Henry St.			*County Code: 079*
	North Vernon, IN 47265		***Eligible provider?***	*RUCA Primary: 7*
	812-352-4200		*Yes, not-for-profit hospital*	*RUCA Secondary: 7.4*
26	***St. Vincent Mercy Hospital***	*MADISON*	*Private*	*Census Tract: 0102.00*
	1331 South A Street			*County Code: 095*
	Elwood, IN 46036		***Eligible provider?***	*RUCA Primary: 7*
	765-552-4594		*Yes, not-for-profit hospital*	*RUCA Secondary: 7.1*
27	***St. Vincent Randolph Hospital***	*RANDOLPH*	*Private*	*Census Tract: 9517.00*
	473 Greenville Avenue			*County Code: 135*
	Winchester, IN 47394		***Eligible provider?***	*RUCA Primary: 7*
	765-584-0141		*Yes, not-for-profit hospital*	*RUCA Secondary: 7.0*
28	***St. Vincent Williamsport Hospital***	*WARREN*	*Private*	*Census Tract: 9510.00*
	412 N. Monroe Street			*County Code: 171*
	Williamsport, IN 47993		***Eligible provider?***	*RUCA Primary: 10*
	765-762-4001		*Yes, not-for-profit hospital*	*RUCA Secondary: 10.1*

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	Hospital Name and Address	County	Public/Profit	RUCA/Census
29	**Sullivan County Community Hospital**	SULLIVAN	Public	Census Tract: 0503.00
	2200 North Section Street			County Code: 153
	Sullivan, IN 47882		**Eligible provider?**	RUCA Primary: 9
	812-268-4311		Yes, not-for-profit hospital	RUCA Secondary: 9.1
30	**Tipton County Memorial Hospital**	TIPTON	Public	Census Tract: 0204.00
	1000 S. Main Street			County Code: 159
	Tipton, IN 46072		**Eligible provider?**	RUCA Primary: 7
	765-675-8501		Yes, not-for-profit hospital	RUCA Secondary: 7.3
31	***Wabash County Hospital***	*WABASH*	*Public*	*Census Tract: 9926.00*
	710 N East Street			*County Code: 169*
	Wabash, IN 46992		***Eligible provider?***	*RUCA Primary: 4*
	260-569-2217		*Yes, not-for-profit hospital*	*RUCA Secondary: 4.0*
32	***Washington County Memorial Hospital***	*WASHINGTON*	*Public*	*Census Tract: 9675.00*
	911 N. Shelby Street			*County Code: 175*
	Salem, IN 47167		***Eligible provider?***	*RUCA Primary: 7*
	812-883-5881		*Yes, not-for-profit hospital*	*RUCA Secondary: 7.3*
33	***West Central Community***	*VERMILLION*	*Private*	*Census Tract: 0205.00*
	801 S. Main Street			*County Code: 165*
	Clinton, IN 47842		***Eligible provider?***	*RUCA Primary: 7*
	765-832-1200		*Yes, not-for-profit hospital*	*RUCA Secondary: 7.1*

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	Hospital Name and Address	County	Public/Profit	RUCA/Census
34	**White County Memorial Hospital**	WHITE	Public	Census Tract: 9585.00
	720 S. Sixth Street			County Code: 181
	Monticello, IN 47960		**Eligible provider?**	RUCA Primary: 8
	574-583-1709		Yes, not-for-profit hospital	RUCA Secondary: 8.3
35	**Woodlawn Hospital**	FULTON	Private	Census Tract: 9531.00
	1400 E. Ninth Street			County Code: 049
	Rochester, IN 46975		**Eligible provider?**	RUCA Primary: 7
	574-224-1173		Yes, not-for-profit hospital	RUCA Secondary: 7.4
Not-for-Profit Rural Hospitals Under 100 Beds (Participants 36-41)				
	Hospital Name and Address	**County**	**Public/Profit**	**RUCA/Census**
36	**Daviess Community Hospital**	DAVIESS	Private	Census Tract: 9549.00
	1314 E. Walnut St.			County Code: 027
	Washington, IN 47501		**Eligible provider?**	RUCA Primary: 4
	812-254-2760		Yes, not-for-profit hospital	RUCA Secondary: 4.0
37	**Hancock Regional Hospital**	HANCOCK	Private	Census Tract: 4106.00
	801 N State Street			County Code: 059
	Greenfield, IN 46140		**Eligible provider?**	RUCA Primary: 2
	317-462-5544		Yes, not-for-profit hospital	RUCA Secondary: 2.0
38	**Henry County Hospital**	HENRY	Private	Census Tract: 9761.00
	1000 N. 16th St.			County Code: 065
	New Castle, IN 47362		**Eligible provider?**	RUCA Primary: 4
	765-521-1502		Yes, not-for-profit hospital	RUCA Secondary: 4.0

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	Hospital Name and Address	County	Public/Profit	RUCA/Census
39	***Johnson Memorial Hospital***	*JOHNSON*	*Private*	*Census Tract: 6108.00*
	1125 W. Jefferson St.			*County Code: 081*
	Franklin, IN 46131		***Eligible provider?***	*RUCA Primary: 4*
	317-736-3300		*Yes, not-for-profit hospital*	*RUCA Secondary: 4.1*
40	***King's Daughters' Hospital and Health Services***	*JEFFERSON*	*Private*	*Census Tract: 9666.00*
	One King's Daughter's Drive			*County Code: 077*
	PO Box 447		***Eligible provider?***	*RUCA Primary: 4*
	Madison, IN 47250		*Yes, not-for-profit hospital*	RUCA Secondary: 4.0
	812-265-0452			
	Urban Partner Hospitals (Participants 42-56)			
	Hospital Name and Address	**County**	**Public/Profit**	**RUCA/Census**
41	**Logansport Memorial Hospital**	CASS	Private	Census Tract: 9512.00
	1101 Michigan Avenue			County Code: 017
	Logansport, IN 46947		**Eligible provider?**	RUCA Primary: 4
	574-753-1386		Yes, not-for-profit hospital	RUCA Secondary: 4.0
42	***Bloomington Hospital***	*MONROE*	*Private*	*Census Tract: 0004.01*
	601 West Second Street			*County Code: 105*
	Bloomington, IN 47403		***Eligible provider?***	*RUCA Primary: 1*
	812-353-9555		*Yes, not-for-profit hospital*	*RUCA Secondary: 1.0*
43	***Clarian Health – Riley Hospital for Children***	*MARION*	*Private*	*Census Tract: 3539.00*
	702 Barnhill Drive			*County Code: 097*
	Indianapolis, IN 46202		***Eligible provider?***	*RUCA Primary: 1*
	317-962-3306		*Yes, not-for-profit hospital*	*RUCA Secondary: 1.0*

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44	***Clarian Health – Indiana University Hospital***	*MARION*	*Private*	*Census Tract: 3539.00*
	550 N. University Blvd.			*County Code: 097*
	Indianapolis, IN 46202		***Eligible provider?***	*RUCA Primary: 1*
	317-962-3306		*Yes, not-for-profit hospital*	*RUCA Secondary: 1.0*
45	**Clarian Health – Methodist Hospital**	MARION	Private	Census Tract: 3533.00
	1801 N. Senate			County Code: 097
	Indianapolis, IN 46202		**Eligible provider?**	RUCA Primary: 1
	317-962-3306		Yes, not-for-profit hospital	RUCA Secondary: 1.0
	Community Health Network – Community Hospitals of Indiana, Inc., Community Hospital East, Community Hospital North, Community Hospital South, The Indiana Heart Hospital			
	Individual site addresses are listed below, however, please quote bids to: DMARC for Disaster Recovery			
	733 West Henry Street			
	Indianapolis, IN 46225			
46	***Community Hospitals of Indiana, Inc. (corporate address)***	*MARION*	*Private*	*Census Tract: 3609.00*
	1500 N. Ritter Avenue			*County Code: 097*
	Indianapolis, IN 46219		***Eligible provider?***	*RUCA Primary: 1*
			Yes, not-for-profit hospital	*RUCA Secondary: 1.0*

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47	***Community Hospital East***	*MARION*	*Private*	*Census Tract: 3609.00*
	1500 N. Ritter Avenue			*County Code: 097*
	Indianapolis, IN 46219		***Eligible provider?***	*RUCA Primary: 1*
	317-355-5930		*Yes, not-for-profit hospital*	*RUCA Secondary: 1.0*
48	***Community Hospital North***	*MARION*	*Private*	*Census Tract: 3301.06*
	7250 Clearvista Parkway			*County Code: 097*
	Indianapolis, IN 46256		***Eligible provider?***	*RUCA Primary: 1*
	317-355-5930		*Yes, not-for-profit hospital*	*RUCA Secondary: 1.0*
49	***Community Hospital South***	*MARION*	*Private*	*Census Tract: 3812.04*
	1402 East County Line Road South			*County Code: 097*
	Indianapolis, IN 46227		***Eligible provider?***	*RUCA Primary: 1*
	317-355-5930		*Yes, not-for-profit hospital*	*RUCA Secondary: 1.0*
50	***The Indiana Heart Hospital***	*MARION*	*Private*	*Census Tract: 3301.06*
	8075 North Shadeland Avenue			*County Code: 97*
	Indianapolis, IN 46256		***Eligible provider?***	*RUCA Primary: 1*
	317-355-5930		*Yes, not-for-profit hospital*	*RUCA Secondary: 1.0*
51	***St. Vincent Health***	*MARION*	*Private*	*Census Tract: 3201.08*
	2001 W. 86th Street			*County Code: 097*
	Indianapolis, IN 46260		***Eligible provider?***	*RUCA Primary: 1*
	317-338-6566		*Yes, not-for-profit hospital*	*RUCA Secondary: 1.0*

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52	***Sisters of St. Francis Health Services, Inc. – St. Francis Hospital & Health Centers – Beech Grove Campus***	*MARION*	*Private*	*Census Tract: 3575.00*
	1600 Albany Street			*County Code: 097*
	Beech Grove, IN 46107		***Eligible provider?***	*RUCA Primary: 1*
	317-532-7800		*Yes, not-for-profit hospital*	*RUCA Secondary: 1.0*
53	***Sisters of St. Francis Health Services, Inc. – St. Francis Hospital & Health Centers – Indianapolis Campus***	*MARION*	*Private*	*Census Tract: 3904.01*
	8111 South Emerson			*County Code: 097*
	Indianapolis, IN 46237		***Eligible provider?***	*RUCA Primary: 1*
	317-532-7800		*Yes, not-for-profit hospital*	*RUCA Secondary: 1.0*
54	***Sisters of St. Francis Health Services, Inc. – St. Francis Hospital & Health Centers – Mooresville Campus***	*MORGAN*	*Private*	*Census Tract: 5102.00*
	1201 Hadley Road			*County Code: 109*
	Mooresville, IN 46158		***Eligible provider?***	*RUCA Primary: 1*
	317-532-7800		*Yes, not-for-profit hospital*	*RUCA Secondary: 1.0*

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	Hospital Name and Address	County	Public/Profit	RUCA/Census
55	***Sisters of St. Francis Health Services, Inc. – St. Clare Medical Center***	*MONTGOMERY*	*Private*	*Census Tract: 9570.00*
	1710 Lafayette Road			*County Code: 107*
	Crawfordsville, IN 47933		***Eligible provider?***	*RUCA Primary: 5*
	317-532-7800		*Yes, not-for-profit hospital*	*RUCA Secondary: 5.2*
56	***Union Hospital, Inc.***	*VIGO*	*Private*	*Census Tract: 0009.00*
	1606 N. 7th Street			*County Code: 167*
	Terre Haute, IN 47804		***Eligible provider?***	*RUCA Primary: 1*
	812-238-7000		*Yes, not-for-profit hospital*	*RUCA Secondary: 1.0*

3. Network Narrative: In the first quarterly report following the completion of the competitive bidding process and the selection of vendors, the selected participant must submit an updated technical description of the communications network that it intends to implement, which takes into account the results its network design studies and negotiations with its vendors. This technical description should provide, where applicable:

a. Brief description of the backbone network of the dedicated health care network, e.g., MPLS network, carrier-provided VPN, a SONET ring;
b. Explanation of how health care provider sites will connect to (or access) the network, including the access technologies/services and transmission speeds;
c. Explanation of how and where the network will connect to a national backbone such as NLR or Internet2;
d. Number of miles of fiber construction, and whether the fiber is buried or aerial;
e. Special systems or services for network management or maintenance (if applicable) and where such systems reside or are based.

a. The backbone network is a combination of DWDM, SONET, and pure Ethernet transport. Primary equipment at hospital premises will be Gigabit Ethernet Switches. Hospitals will have access to dedicated Ethernet transport from the individual hospitals to the common meet point in downtown Indianapolis, where we will have a gateway to the public internet.

b. We intend to build fiber optic cable directly into the hospitals and "lighting" the building with Gigabit Ethernet Switches. Some healthcare participants will connect to the public internet via their local POP with their winning vendor. Other healthcare participants will connect to the public internet at the common meet point via dedicated Ethernet transport. The connection speeds will be 10, 50, and 100 Mbps handed off via 10/100 Ethernet connections. Final bandwidth determinations have not yet been made by all hospitals. At this time, approximately 56% of hospitals have chosen 10 mbps connections, 28% have chosen 50 mbps connections, and 16% have chosen 100 mbps connections.

c. The network will connect to the public internet at a common meetpoint at 701 West Henry Street in Indianapolis. Future connections to the NLR and/or Internet2 are possible via the common meetpoint at the Carrier Hotel located on Henry St. in Indianapolis, IN.

d. As of December 31, 2010, approximately 160 miles of fiber has been constructed. Of the 160 miles, 80% is aerial.

e. We have contracted with the Indiana Fiber Network for network management and maintenance. Their Network Operations Center (NOC) is located at 5520 West 76th St., Indianapolis, Indiana. The NOC is staffed and back with technicians who have a wide range of technical expertise. The NOC keeps watch on DWDM, Sonet, Ethernet, SS7 and MPLS hardware. The Indiana Telehealth Network is monitored 24x7x365 and hardware events are recorded in the NOC Network Monitoring System (NMS). The ITN Shared platform/gateway to the Internet is monitored via 2 NMS systems - the main NMS system as well as a secondary system. The secondary system acts as the primary gateway for customer visibility into their port. The ITN dedicated NMS will allow each healthcare participant access to utilization and outage information regarding their point of access (port). Each healthcare participant can have multiple users access the NMS portal and request restrictions based on username.

4. List of Connected Health Care Providers: Provide information below for all eligible and non-eligible health care provider sites that, as of the close of the most recent reporting period, are connected to the network and operational.

a. Health care provider site
b. Eligible provider (Yes/No);
c. Type of network connection (e.g., fiber, copper, wireless);
d. How connection is provided (e.g., carrier-provided service; self-constructed; leased facility);
e. Service and/or speed of connection (e.g., DS1, DS3, DSL, OC3, Metro Ethernet (10 Mbps);
f. Gateway to NLR, Internet2, or the Public Internet (Yes/No);
g. Site Equipment (e.g., router, switch, SONET ADM, WDM), including manufacturer name and model number.
h. Provide a logical diagram or map of the network.

a. & b. As detailed in the answer to question 2 above, all of our sites are eligible providers. No sites were connected during the first quarter of 2010. During the second quarter of 2010, construction and/or installation of upgraded equipment has started at the 5 hospitals for which we have received FCLs. During the third quarter of 2010, construction and/or installation of upgraded equipment was started at an additional 5 of the 10 hospitals for which we have received FCLs. The following table contains information on sites that are connected as of December 31, 2010.

Hospital	How connection is provided (e.g., carrier-provided service, self-constructed, leased facility)	Service and/or Speed of Connection	Site Equipment (e.g., router, switch, SONET ADM, WDM), including manufacturer name and model number
Bedford Regional Medical Center	Previously Constructed	Digital Contract for Scalable Ethernet	Cisco 3750 Router
Clarian Health - Data Center	Collocated Facilities	100 mbps	N/A
Community Health Network - Data Center	Collocated Facilities	100 mbps	N/A
Community Hospital of Bremen	carrier provided service	10 mbps	Cisco 15310 SONET
Decatur County Memorial Hospital	carrier provided service	10 mbps	Cisco 3750, Calix ONT
Henry County Hospital	carrier provided service	50 mbps	Occam 6450 and Cisco 3400
Logansport Memorial Hospital	carrier provided service	50 mbps	Ciena 310
Margaret Mary Community Hospital	carrier provided service	10 mbps	Cisco 3750
Perry County Memorial Hospital	carrier provided service	50 mbps	3Com Baseline Switch 2924-SFP Plus
Pulaski Memorial Hospital	carrier provided service	10 mbps	Cisco Router ASA 5510
Rush Memorial Hospital	carrier provided service	10 mbps	Occam 6450 and Cisco 3400
Sullivan County Community Hospital	Previously Constructed	Digital Contract for Scalable Ethernet	Cisco 3750 Router
Tipton Hospital	Previously Constructed	50 mbps	Cisco 3750 Switch
White County Memorial Hospital	carrier provided service	100 mbps	Cisco Router 2960
Woodlawn Hospital	Previously Constructed	50 mbps	Switch - SISCO - SRW2008MP

c. All connections are fiber.

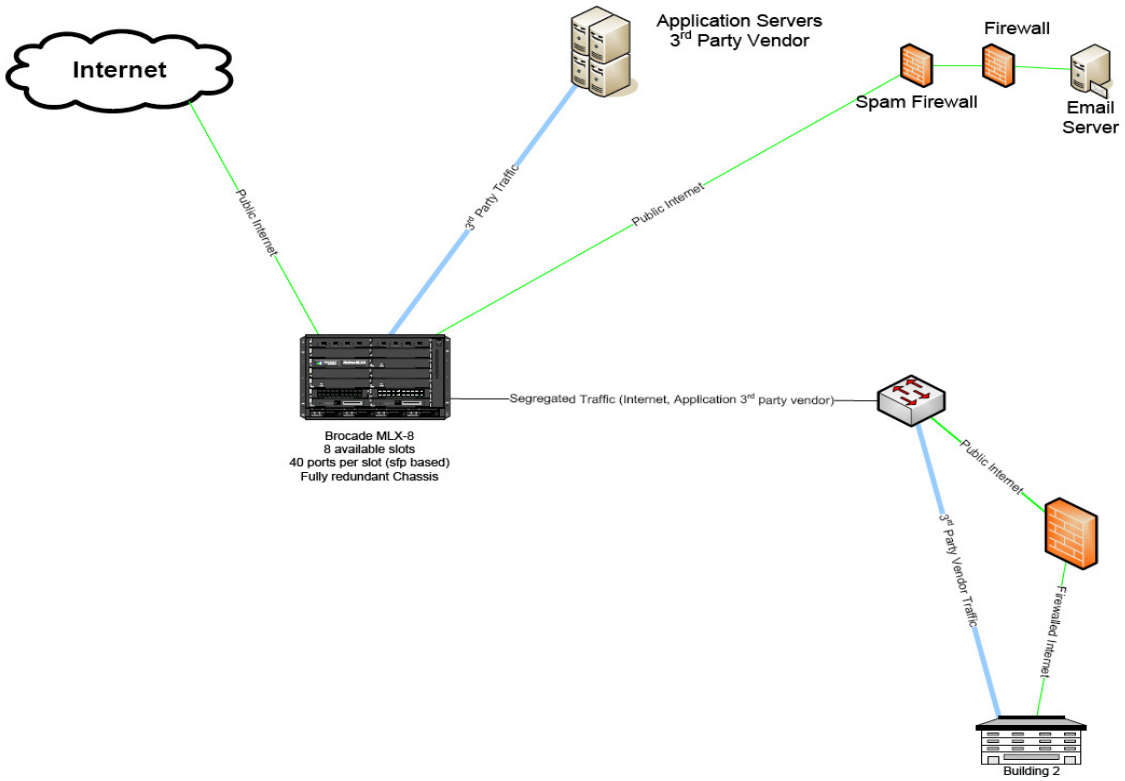
d. All connections are via carrier-provided services.

e. Connection speeds are all Ethernet, and will vary from 10 mbps to 100 mbps per site.

f. At this time, we are only connecting our healthcare participants to the public internet.

g. Site equipment has not yet been finalized for all sites.

h. Network diagrams have been provided to USAC with the individual contracts, as requested. Once all contracts are signed, we will have 8 different vendors providing services to our participants. See below for a representative network diagram.



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5. Identify the following non-recurring and recurring costs, where applicable shown both as budgeted and actually incurred for the applicable quarter and funding year to-date.

a. Network Design
b. Network Equipment, including engineering and installation
c. Infrastructure Deployment/Outside Plant
    i. Engineering
    ii. Construction
d. Internet2, NLR, or Public Internet Connection
e. Leased Facilities or Tariffed Services
f. Network Management, Maintenance, and Operation Costs (not captured elsewhere)
g. Other Non-Recurring and Recurring Costs

a. As of December 31, 2010, the ITN has not budgeted for nor actually incurred any costs for network design.
b. As of July 28, 2010, the ITN has budgeted for (but not yet incurred) $97,500 for network equipment, engineering and installation. Of that amount, 85% will be invoiced to USAC, and the remaining 15% will be paid by the individual participants.
c. As of July 28, 2010, the ITN has budgeted for (but not yet incurred) $3,268,105.60 for infrastructure deployment, outside plant, engineering or construction. Of that amount, 85% will be invoiced to USAC, and the remaining 15% will be paid by the individual participants.
    - As of October 28, 2010, the ITN has incurred costs for approximately $103,000 for infrastructure deployment, outside plant, engineering or construction. Of that amount, 85% was invoiced to USAC, and the remaining 15% was paid by the individual participants.
    - As of December 31, 2010, the ITN has revised our budget for infrastructure deployment, outside plant, engineering or construction to $1,465,089.60 (85% or $1,245,326.16 will be billed to USAC). Of that amount, invoices have actually been paid for $307,478.33.
d. As of July 28, 2010, the ITN has budgeted for (but not yet incurred) $418,892.500 for Public Internet Connections. Of that amount, 100% will be paid by the individual participants. We have been working directly with USAC to transition the participants who are eligible for the USAC Primary/Regular RHC Program, so that they can take advantage of the 25% discounts on Internet Services from that program.
    - In November 2010, the ITN submitted a "Change of Scope" document to include monthly recurring charges as eligible expenses for our project. The "Change in Scope" document was approved in January 2011. We will begin invoicing for Public Internet Connections once our revised Sustainability Plan has been approved.
e. We have not budgeted for nor actually incurred any costs for Internet2 or NLR connections.

f. As of July 28, 2010, the ITN does not plan to budget for nor incurred any costs for leased facilities or Tariffed services.
g. As of July 28, 2010, the ITN has budgeted for (but not yet incurred) $450,000 for network management, maintenance, and operation costs. Of that amount, 85% will be invoiced to USAC, and the remaining 15% will be paid by the individual participants.
h. As of July 28, 2010, the ITN has budgeted for (but not yet incurred) $188,577.50 for recurring charges for dedicated transport to the public internet gateway. Of that amount, 100% will be paid by the individual participants. We have been working directly with USAC to transition the participants who are eligible for the USAC Primary/Regular RHC Program, so that they can take advantage of the rural-urban discounts from that program.
    - In November 2010, the ITN submitted a "Change of Scope" document to include monthly recurring charges as eligible expenses for our project. The "Change in Scope" document was approved in January 2011. We will begin invoicing for dedicated transport charges once our revised Sustainability Plan has been approved.

6. Describe how costs have been apportioned and the sources of the funds to pay them:

a. Explain how costs are identified, allocated among, and apportioned to both eligible and ineligible network participants.
b. Describe the source of funds from:
i. Eligible Pilot Program network participants
ii. Ineligible Pilot Program network participants
c. Show contributions from all other sources (e.g., local, state, and federal sources, and other grants).
i. Identify source of financial support and anticipated revenues that is paying for costs not covered by the fund and by Pilot Program participants.
ii. Identify the respective amounts and remaining time for such assistance.
d. Explain how the selected participant's minimum 15 percent contribution is helping to achieve both the selected participant's identified goals and objectives and the overarching goals of the Pilot Program.

a. As of March 31, 2010, the ITN has completed the selection process for the winning vendors. All of our proposed participants are eligible participants. All common costs will be divided equally among all participating hospitals. Any ineligible participants that may or may not join the network at a later date will be required to pay their fair share to join the network.
b. Funding from participants
    i. All participants are currently eligible. Eligible pilot program participants will contribute 15% of their own construction costs, based on the

individual pricing presented by their winning bidder. All eligible participants will also be responsible for 15% of their common network costs, should they choose to participate in Phase II of the RFP. All eligible participants are also responsible for their own connection charges to the common meet point (if applicable) and the public internet.

ii. At this time, we have no ineligible Pilot Program network participants. We have had several requests from ineligible entities to participate in the network, and are currently discussing processes and procedures to allow for this.

c. Contributions from other sources

i. The state of Indiana, through the Office of Community and Rural Affairs (OCRA), has supported the program administration of this project through a rural development grant. Program administration is identified as an ineligible cost for the FCC RHCPP, as listed in paragraph 75 of the FCC Order 07-198.

ii. This funding, totaling approximately $250,000, has allowed IRHA to administer this project during 2008 and 2009. This funding will sunset at the end of April 2010. IRHA will be providing in-kind support for program administration of this project for one year, or until other grant funding can be obtained.

d. The 15% contributions, which will come almost exclusively from the healthcare participants, will assist the ITN by bringing the conceptual designs of the network to fruition. The overarching goals of the Pilot Program will be fulfilled in the state of Indiana by the creation of a statewide dedicated broadband healthcare network.

7. Identify any technical or non-technical requirements or procedures necessary for ineligible entities to connect to the participant's network.

- As detailed in the answer to question 2 above, our current participant list includes only eligible entities.
- As mentioned above, we have had several requests from ineligible entities to connect to this network. We are currently discussing processes and procedures to allow for this. Prior to connecting to the network, any ineligible entity will be required to pay their fair share to connect to the network.

8. Provide an update on the project management plan, detailing:

a. The project's current leadership and management structure and any changes to the management structure since the last data report; and

b. In the first quarterly report, the selected applicant should provide a detailed project plan and schedule. The schedule must provide a list of key project deliverables or tasks, and their anticipated completion dates. Among the deliverables, participants must indicate the dates when each health care provider site is expected to be connected to the network and operational. Subsequent quarterly reports should identify which project deliverables, scheduled for the previous quarter, were met, and which were not met. In the event a project deliverable is not achieved, or the work and deliverables deviate from the work plan, the selected participant must provide an explanation.

- The Indiana Rural Health Association (IRHA) is the Lead Applicant for the Indiana Telehealth Network.
- The Indiana Telehealth Network established an Advisory Board, known as the FCC Pilot Project Steering Committee as of September 2008, made up of the Plan Co-Applicants and the Office of Community and Rural Affairs. The Advisory Board members are listed below:
    - Don Kelso, Executive Director, IRHA and the Project Coordinator for the Indiana Telehealth Network
    - Becky Sanders, FCC Pilot Program Associate Project Coordinator, IRHA and Associate Project Coordinator for the Indiana Telehealth Network
    - John Winenger, MBA, FACHE, Regional Network Consultant, Network Development, St. Vincent Health
    - Jennifer Baron, Program Director, Telemedicine, Clarian Health
    - Erik Southard, RN, MS, CFNP, DNPs, Administrator, Richard G. Lugar Center for Rural Health
    - Stephanie Laws, Project Associate, Richard G. Lugar Center for Rural Health John Koppin, CAE, President, Indiana Telecommunications Association
    - Mark McMath, Vice President, Chief Information Officer, Administration, Bloomington Hospital
    - Geoff Schomacker, Project Manager, Indiana Office of Community and Rural Affairs
    - David Terrell, Executive Director, Indiana Office of Community and Rural Affairs
    - Tim McGeath, Attorney, Hall, Render, Killian, Heath & Lyman, P.C.
    - Jonathan Neufeld, PhD, Indiana Rural Health Specialty Exchange
- As of September 2010, our Advisory Board has been restructured to reflect more participation from Community Health Centers, Community Mental Health Centers, Federally Qualified Health Centers, and Rural Health Clinics, who will be participating in our next RFP#01 that we hope to have posted before the end of 2010. The revised list of Advisory Board members are listed below:
    - Don Kelso, Executive Director, IRHA and the Project Coordinator for the Indiana Telehealth Network

- Becky Sanders, Network Development Coordinator, IRHA and Associate Project Coordinator for the Indiana Telehealth Network
- Jennifer Baron, Program Director, Telemedicine, Indiana Clinic
- Geoff Schomacker, Project Manager, Indiana Office of Community and Rural Affairs
- Jonathan Neufeld, PhD, Indiana Rural Health Specialty Exchange
- Jim Miller, Special Projects Coordinator, IRHA
- Matt Serricchio, Associate Network Director, IRHA
- Charlie Sharp, Data/Voice Communications Manager, Indiana Office of Technology
- Jim Stewart, Director of IT, Aspire

- **Project Plan and Schedule**
  - The first two columns in the table below are taken directly from Section 1.23 of our RFP. The last column includes actual project dates – both completed and projected.

Indiana Telehealth Network RFP Timeline

Activity	Date	Actual Dates
Issue of RFP	Date posted on USAC website	June 30, 2009 (met as planned)
Deadline to Submit Written Questions	10 Business Days after posting on USAC website	July 15, 2009 (met as planned)
Response to Written Questions/RFP Amendments	17 Business Days after posting on USAC website	July 24, 2009 (met as planned)
Submission of Proposals	45 Business Days after posting on USAC website	September 2, 2009 (met as planned)

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The dates for the following activities are target dates only. These activities may be completed earlier or later than the date shown.		
Proposal Evaluation/ Clarifications if Necessary	120 Business Days after posting on USAC website	December 21, 2009 (met as planned)
Best and Final Offers (if necessary)	135 Business Days after posting on USAC website	January 14, 2010 (met as planned)
Contract Award	180 Business Days or sooner after submission due date	March 18, 2010 (on track to sign contract at the end of April, 2010)

- All activities in the above listed timeline were completed as planned. We had hoped to sign contracts with the winning vendors on or before March, 18, 2010. However, contract negotiations have taken longer than we anticipated.
- We did start signing contracts by the end of April, 2010.
- As of July 28, 2010, we have submitted seven (7) 466-A packages to USAC for approval, representing six (6) vendors and nine (9) hospitals. We have received Funding Commitment Letters for five (5) hospitals. Construction and/or equipment upgrades have started at the locations where FCLs have been received.
    - We hope to have the common meet point operational in the September/October 2010 timeframe.
    - We still have several contracts outstanding. While final timelines are dependant upon contract signing and issuance of FCLs from USAC, we hope to have the majority of the participating hospitals connected by the end of 2010.
- As of September 30, 2010, we have submitted a total of eight (8) 466-A packages to USAC for approval, representing all eight (8) of our vendors and ten (10) hospitals. We have received funding commitment letters for ten (10) hospitals in the amount of around $900,000.
    - By the end of 2010, we expect construction and/or installation of upgraded equipment to be completed at the majority of these locations. The Indiana Telehealth Network gateway to the public internet went live mid-October 2010.
- As of December 31, 2010, we have submitted a total of fifteen (15) 466-A packages to UASC for approval, representing all eight (8) of our vendors and eleven (11) hospitals. We have received FCLs for all 11 hospitals in the amount of $1,080,165,57.

9. Provide detail on whether network is or will become self sustaining. Selected participants should provide an explanation of how network is self sustaining.

- The ITN proposes to become self-sustaining. As mentioned in our grant application, ITN has identified each rural hospital as the "anchor tenant" in each rural community. Hospitals are often the largest employers in small rural markets. They often consist of the largest total number user of computers users and, therefore, need strong internet connectivity. Hospital administrators are also frequent participants in local community planning exercises and actively working with local business leaders to discuss economic development. These discussions include community needs assessments and holding local community leaders accountable for enhancing services so that rural communities can remain local in getting the services they need to function effectively in all areas of their lives, including healthcare. Therefore, it is our professional judgment that using the rural hospitals as the anchor customer will provide a strong economic position for future growth of the network in each community, which will enhance the overall network's financial sustainability.
- The ITN proposes to use Pilot Program funds for non-recurring construction and installation charges incurred during the creation of the Indiana Telehealth Network.
- The ITN proposes to use additional Pilot Program funds for common network operations, maintenance, and management.
- We propose that our healthcare participants be responsible for paying their own monthly recurring charges for connectivity, just as they did before the Rural Health Care Pilot Program. Based on the best and final bids received in January 201, many of our healthcare participants will be able to obtain higher bandwidth for costs similar to what they were paying before the RHCPP. In our RFP, we asked bidders to provide pricing information for 10 mbps, 50 mbps, 100 mbps, and 1 gbps. This allows our hospitals participants to choose the bandwidth that best meets their needs as well as their budgets.
- We propose to further assist our healthcare participants by taking advantage of the regular USAC Rural Health Care Program. In this manner, we expect to minimize any increases in connectivity costs for monthly recurring charges incurred as a result of this program. Out of our 56 FCC RHCPP eligible participants, 40 are eligible for the regular USAC RHC program, including all 35 of the Critical Access Hospitals, 4 of the rural hospitals, and 1 of the urban hospitals.
- We have identified several revenue streams that will assist us in maintaining a self-sustaining network.
- As detailed above, our RFP was posted on June 30, 2009. Vendors' responses were submitted on September 2, 2009. Best and Final offers from the vendors were received on January 14, 2010. We had hoped to sign contracts with our winning vendors on or before March 18, 2010, but contract negotiations have taken longer than we anticipated. We started signing contracts at the end of April, 2010.

- As noted in the answer to questions 5 and 6 above, we are only seeking assistance from USAC for construction and non-recurring charges. All contracts are between the individual participants and their winning vendors. We have been working with USAC to transition the participants who are eligible for the USAC Regular/Primary Program to that program for assistance with recurring charges.
- IRHA is continuing to fund all program administration, as that is an ineligible cost. Additional revenue streams have been identified that will assist us with that cost in the near future.
- In November 2010, the IRHA submitted a "Change in Scope" document to include monthly recurring charges. When the ITN budget was originally compiled for inclusion in the grant application in May 2007, monthly recurring charges were not factored in; individual hospitals would be responsible for those incurred expenses. However, construction costs, originally estimated at $40,000/mile, were, in actuality, significantly lower. Through the RFP process, winning bids averaged at approximately $15,000/mile. That variance, coupled with less-than-expected contracted participation from rural Indiana hospitals – only 22 of the anticipated 56 participants have signed contracts due to a variety of financial reasons – has earmarked only $2.0 million of the $16.0 million awarded to the Indiana Telehealth Network (ITN). To offset, in part, this gap in funding commitment, ITN has proposed inclusion of monthly recurring charges as part of its sustainability plan. It is estimated that inclusion of monthly recurring charges would increase FCL expected invoice totals by approximately $5 million to approximately $7.0 million. Our change of scope document was approved in January 2011.
- In November 2010, the IRHA submitted a request to the FCC for a one-year waiver to extend the deadline for the submission of 466-A packages. We would like the opportunity to release another RFP with the intention of expanding the ITN to additional eligible HCPs and utilizing all of our RHCPP funding.
- The ITN also submitted RFP#01 to USAC for review in November 2010.
- The ITN submitted a revised Sustainability Plan with the "Change in Scope" document in November 2010. Based on preliminary reviews by USAC, an updated Sustainability Plan with a 10-year budget will be filed with USAC in conjunction with this Quarterly Report. Following is detail from our updated Sustainability Plan:

ITN Funding Sources - Years 1-5 (2010 – 2015)

- Non-Recurring Costs
  - USAC Rural Health Care Pilot Program (RHCPP)
    - In years 1-5 of the program, all eligible non-recurring, including construction, network equipment, engineering, and installation costs will be paid 85% from the USAC RHCPP and 15% from the individual healthcare participant, based on the individual contract between the HCP and their winning vendor. Due to current economic conditions, efforts to secure assistance with the 15% match from statewide funding were not successful. Each participant is responsible

for meeting their own 15% contribution. These contributions typically come from the individual hospital or its foundation. Information on the USDA Community Facilities Program for communities less than 20,000 has been shared with individual hospitals as appropriate.

- Monthly Recurring Costs
  - USAC Rural Health Care Pilot Program (RHCPP)
    - In years 1-5 of the program, recurring charges for the network operations, network maintenance, and network management will be paid 85% from the USAC RHCPP and 15% from the individual healthcare participants.
    - In years 1-5 of the program, monthly connection charges (in bandwidths of 10 mbps, 50 mbps, 100 mbps, or 1 gbps) will be paid 85% from the USAC RHCPP and 15% by the individual healthcare participants. Each healthcare participant currently has a budget for communications costs, and was given the opportunity to choose a level of bandwidth based on their need and financial ability to cover their portion of the recurring charges for the associated service.
  - Administrative Support
    - In year 1 (July 1, 2010 – June 30, 2011), IRHA is offering administrative support to this program as an in-kind contribution. Beginning July 2011, IRHA will begin charging each HCP $200/month ($2,400/year) to offset the administrative costs of the ITN which is an ineligible expense for the Federal Communications Commission's Rural Health Care Pilot Program (FCC RHCPP).
- Non-eligible healthcare entities
  - While all of our current HCPs are eligible for the RHCPP, we have been approached by several non-eligible healthcare entities who would like to have access to the ITN. Discussions regarding processes and procedures for allowing non-eligible healthcare entities access to the Indiana Telehealth Network are ongoing. We have finalized the fair-share costs for these non-eligible entities, and any funds received from these entities would be used 1) to offset any IRHA administrative costs, and 2) to offset future network operations, network maintenance, and network management costs, and 3) for future development and investment purposes of the ITN. The fair-share costs for each entity desiring access to the ITN shared platform/gateway to the Internet were determined based on a calculation of 1/20th of the non-recurring construction and installation charges for the creation of the ITN shared platform. The rational for dividing these common costs by 1/20th was made based on the number of eligible HCPs from our RFP#00 who signed letters of intent to sign contracts with a winning vendor at the end of the competitive bidding process. For eligible HCPs listed in our RFP#00 or RFP#01, this amount will be split between the RHCPP (at 85%) and the individual HCP (at 15%). Non-eligible healthcare entities will be responsible for 100% of their 1/20th of the non-recurring construction and installation charges.

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Table 1.
Summary of Costs & Revenue Sources for the Indiana Telehealth Network
Project Years 1-5 (July 1, 2010 – June 30, 2015)

Table 1 shows an example of a cost and revenue source breakdown, from the ITN, at a general level. In it are listed the non-recurring cost of construction for the fiber network, and the recurring costs for managing the network. Also identified is the corresponding funding source for each cost. The vast majority of our participating eligible healthcare participants are also currently eligible for USAC's primary Rural Health Care program and, as mentioned above, we will be working with USAC RHCPP and USAC RHC personnel to transition those eligible healthcare participants to the primary RHC program once the RHCPP funding has sunset.

Network Costs	**Revenue Sources 2010-2011**		**Revenue Sources 2011-2015**	
Non-Recurring Construction Costs	**85%**	**15%**	**85%**	**15%**
Fiber construction	USAC RHCPP $	Match $	USAC RHCPP $	Match $
Fiber Network equipment	USAC RHCPP $	Match $	USAC RHCPP $	Match $
Server construction	USAC RHCPP $	Match $	USAC RHCPP $	Match $
Outbuildings, POP, etc.	USAC RHCPP $	Match $	USAC RHCPP $	Match $
Recurring Costs	**Revenue Sources 2010-2011**		**Revenue Sources 2011-2012**	
Network Administrative Staff Support (PC & APC)	IRHA in-kind contribution		Combination of IRHA in-kind contribution & ITN Administrative Fees	
Network Operations	USAC RHCPP $	Match $	USAC RHCPP $	Match $
Network Maintenance	USAC RHCPP $	Match $	USAC RHCPP $	Match $
Network Management	USAC RHCPP $	Match $	USAC RHCPP $	Match $
Connection Charges (Ethernet & Public Internet Charges)	USAC RHCPP $	Match $	USAC RHCPP $	Match $
Network Charges (Internet2/ National LambdaRail)*** At this time, we do not plan to connect to Internet2, but have included this as an optional cost that could covered at 85% by USAC RHCPP funding	USAC RHCPP $	Match $	USAC RHCPP $	Match $

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Rollup Years 1-5 RFP #00 Participants	Sub Totals	USAC RHCPP 85%	Eligible HCP Participant RHCPP 15% Match	IRHA In-Kind Contributions	Remaining Participant Costs - Paid by individual hospitals to winning vendors per individual hospital contracts
Construction Costs	($1,431,869.60)	$1,217,089.16	$214,780.44	$0.00	$0.00
Phase I - Local Internet (NRCs and MRCs)	($2,338,770.00)	$1,987,954.50	$350,815.50	$0.00	$0.00
Phase II Dedicated Transport to Common Platform/Gateway to the Public Internet (NRCs and MRCs)	($1,784,290.00)	$1,516,646.50	$267,643.50	$0.00	$0.00
Phase II Aggregated Bandwidth (available at $25 per mbps) (NRCs and MRCs)	($1,665,000.00)	$1,415,250.00	$249,750.00	$0.00	$0.00
Common Platform Costs					
Non-Recurring Charges (first 20 HCPs)	($87,750.00)	$74,587.50	$13,162.50	$0.00	$0.00
Annualized Monthly Recurring Charges (first 20 HCPs)	($621,000.00)	$344,250.00	$60,750.00	$43,200.00	($172,800.00)

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Non-Recurring Charges (above 20 HCPs)	**($97,500.00)**	**$82,875.00**	**$14,625.00**	**$0.00**	**$0.00**
Annualized Monthly Recurring Charges (above 20 hospitals)	**($345,000.00)**	**$191,250.00**	**$33,750.00**	**$0.00**	**$0.00**
Grand Totals w/o Ineligible Entity Contributions or IRHA Admin Costs for USAC Budgeting Purposes	**($8,371,179.60)**	**$6,829,902.66**	**$1,205,276.94**	**$43,200.00**	**($172,800.00)**
Fair Share Initial Buy-In For Ineligible Entities	**$552,125.00**	**$0.00**	**$0.00**	**$0.00**	**$552,125.00**
Annual fees for Ineligible Entities continuing their participation in after Initial Year One Buy In:	**$483,000.00**	**$0.00**	**$0.00**	**$0.00**	**$483,000.00**
IRHA Administrative Costs (PC & APC)	**($517,341.73)**				**($517,341.73)**

Grand Total with Ineligible Entity Contributions & IRHA Admin Costs for ITN Sustainability Purposes	**($7,853,396.33)**	**$6,829,902.66**	**$1,205,276.94**	**$43,200.00**	**$344,983.27**

ITN Funding Sources - Years 6-10 (2015 – 2020)

- Non-Recurring Costs
  - We do not anticipate any non-recurring costs in years 6-10.
- Recurring Costs
  - USAC Rural Health Care Primary/Regular Program (RHC)
    - With the exception of Clarian Health, Community Health Network, and Hancock Regional Hospital, all of our eligible healthcare participants under the USAC RHCPP RFP #00 are also eligible for funding under the primary USAC RHC program. We will continue to work directly with USAC RHCPP personnel and USAC RHC personnel to facilitate the transition our eligible healthcare participants from the pilot to the primary program.
    - Dedicated Monthly Connection Charges
      - In many cases, the monthly connection charges that we have been able to procure through the RHCPP have allowed our healthcare participants to obtain higher bandwidth for costs similar to what they were paying prior to the RHCPP. By 2015, we anticipate bandwidth costs to decrease by 10%.
      - Based on the current urban/rural differential calculations for the RHC program, we estimate our eligible HCPs would receive support of around $666/month to assist with their dedicated connection charges.
      - Any monthly dedicated connection charges not covered by the RHC program will be the responsibility of the HCP, based upon their individual contract with their winning vendor.
    - Monthly Internet Charges
      - Based on the current RHC program, we anticipate our eligible HCPs would receive support for 25% of their monthly internet charges.
      - Based on the current Universal Service FCC 10-125 NPRM, this subsidy may increase in the future, providing further benefit to these participants transitioning from the Pilot Program to the Primary Program.

- Any monthly internet charges not covered by the RHC program will be the responsibility of the HCP, based upon their individual contract with their winning vendor.

- Administrative Support
  - Based upon projections of revenues from non-eligible healthcare entities, the IRHA anticipates that their will be no need to continue charging an administrative fee to our eligible HCPs in years 6-10. Funds received non-eligible from these entities will be used 1) to offset any IRHA administrative costs, and 2) to offset future network operations, network maintenance, and network management costs, and 3) for future development and investment purposes of the ITN.

Table 2.
Summary of Costs & Revenue Sources for the Indiana Telehealth Network
Project Years 6-10 (July 1, 2015 – June 30, 2020)

Once the RHCPP ends, the ITN HCPs will bear the additional costs of the common network operations, maintenance, management, administrative support, as well as any network charges for Internet2 or the National Lambda Rail.

In this transitional year 6, 2015-2016, we will re-examine the costs of the common network and administrative needs in order to assess the appropriate fair-share participation fees on all healthcare participants. We will also examine any revenues generated by non-eligible healthcare entities and the additional value added services that will be made available to participants, as mentioned in "Terms of Membership in the Network" section below.

Network Costs	Revenue Sources 2015-2020
Network Administrative Staff Support (PC & APC)	Ineligible HCP and value added services revenues
Network Operations	Eligible HCPs/ Ineligible HCP and value added services revenues
Network Maintenance	Eligible HCPs/ Ineligible HCP and value added services revenues
Network Management	Eligible HCPs/ Ineligible HCP and value added services revenues
Connection Charges (Dedicated & Public Internet Charges)	USAC RHC / HCPs
Network Charges (Internet2/ National LambdaRail) *** At this time, we do not plan to connect to Internet2, but have included this as an optional cost	Eligible HCPs/ Ineligible HCP and value added services revenues

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Rollup Years 6-10 RFP #00 Participants	Sub Totals	USAC RHC Program 25% Internet Discount	USAC RHC Urban/Rural Differential	IRHA In-Kind Contributions	Remaining Participant Costs - Paid by individual hospitals to winning vendors per individual hospital contracts
Construction Costs	$0.00	$0.00	$0.00	$0.00	$0.00
Phase I - Local Internet (MRCs)	($2,082,645.00)	$520,661.25	$0.00	$0.00	$1,561,983.75
Phase II Dedicated Transport to Common Platform/Gateway to the Public Internet (MRCs)	($1,598,211.00)	$0.00	$719,280.00	$0.00	$878,931.00
Phase II Aggregated Bandwidth (available at $25 per mbps)	($1,498,500.00)	$374,625.00	$0.00	$0.00	$1,123,875.00
Common Platform Costs					
Non-Recurring Charges (first 20 HCPs)	$0.00	$0.00	$0.00	$0.00	$0.00
Annualized Monthly Recurring Charges (first 20 HCPs)	($621,000.00)	$0.00	$0.00	$216,000.00	($405,000.00)

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Non-Recurring Charges (above 20 HCPs)	**($121,875.00)**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Annualized Monthly Recurring Charges (above 20 hospitals)	**($1,207,500.00)**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Grand Totals w/o Ineligible Entity Contributions or IRHA Admin Costs for USAC Budgeting Purposes	**($7,129,731.00)**	**$895,286.25**	**$719,280.00**	**$216,000.00**	**$3,159,789.75**
Fair Share Initial Buy-In For Ineligible Entities	**$552,125.00**	**$0.00**	**$0.00**	**$0.00**	**$552,125.00**
Annual fees for Ineligible Entities continuing their participation in after Initial Year One Buy In:	**$1,690,500.00**	**$0.00**	**$0.00**	**$0.00**	**$1,690,500.00**
IRHA Administrative Costs (PC & APC)	**($599,740.85)**			**$599,740.85**	**$0.00**

Grand Total with Ineligible Entity Contributions & IRHA Admin Costs for ITN Sustainability Purposes	**($5,486,846.85)**	**$895,286.25**	**$719,280.00**	**$815,740.85**	**$5,402,414.75**

10. Provide detail on how the supported network has advanced telemedicine benefits:

a. Explain how the supported network has achieved the goals and objectives outlined in selected participant's Pilot Program application;
b. Explain how the supported network has brought the benefits of innovative telehealth and, in particular, telemedicine services to those areas of the country where the need for those benefits is most acute;
c. Explain how the supported network has allowed patients access to critically needed medical specialists in a variety of practices without leaving their homes or communities;
d. Explain how the supported network has allowed health care providers access to government research institutions, and/or academic, public, and private health care institutions that are repositories of medical expertise and information;
e. Explain how the supported network has allowed health care professional to monitor critically ill patients at multiple locations around the clock, provide access to advanced applications in continuing education and research, and/or enhanced the health care community's ability to provide a rapid and coordinated response in the event of a national crisis.

- While the ITN does not anticipate actual construction of the physical fiber optic network to begin until the end of 2nd quarter 2010, ITN is working with several organizations throughout the state and are facilitating ongoing discussions regarding the goals and objectives outlined in our Pilot Program application. These organizations include:
- **HealthBridge**
  - HealthBridge is a not-for-profit health information exchange serving in the Greater Cincinnati tri-state area. Founded in 1997, HealthBridge is one of the nation's largest and most successful community health information exchanges.
  - HealthBridge recently launched its new Tri-State Regional Extension Center (REC). The Tri-State REC will help physicians and other medical professionals switch from paper records to using cutting-edge information technology to improve patient care.
  - The Tri-State REC was founded through a $9.7 million federal grant. The goal of this new initiative is to help more than 1,700 physicians with the switch to electronic health records.

- The Tri-State REC will serve southwestern Ohio, northern and northeastern Kentucky and southeastern Indiana. HealthBridge has partnered with HealthLINC to provide services to several counties in southeastern Indiana.
- HealthBridge is also part of the Greater Cincinnati community that received one of the 17 Beacon Community Program awards. A part of the Recovery Act, the Beacon Community Program is aimed at achieving measurable improvements in health care quality, safety and efficiency in selected communities.

- **HealthLINC**
  - HealthLINC is a Health Information Exchange that serves a 10-county area in South Central Indiana and includes Bloomington Hospital of Orange County as a participant.
  - The mission of HealthLINC is to provide the infrastructure, support services, and a collaborative environment that enable providers and public health to share clinical information across organizational lines to improve the quality, safety, and efficiency of care in South Central Indiana.
- **Indiana Health Information Technology, Inc (IHIT)**
  - The State of Indiana has made significant progress during the last 15 years in establishing an effective sustainable network of health information exchange (HIE) to support healthcare providers and enhance the quality of the state's healthcare system. The Governor of Indiana has established Indiana Health Information Technology, Inc. (IHIT) as the state designated entity to build on this early work of the five successful private sector health information organizations (HIOs) (HealthBridge, HealthLINC, Indiana Health Information Exchange (together with its partner the Regenstrief Institute), Medical Informatics Engineering, and Michiana Health Information Network (MHIN).
  - IHIT has developed a Strategic and Operational Plan for
    - increasing HIE adoption in rural and underserved areas across the state, leading to statewide HIE coverage
    - expanding and developing additional health information exchange services necessary for achieving "meaningful use" of health information technology
    - establishing a governance structure that achieves broad-based stakeholder collaboration with transparency, buy-in and trust
    - identifying a path to continued sustainability by managing financial resources necessary to fund the State's HIE Strategic and Operational Plan
    - expanding the technical infrastructure capabilities that physically enable health information exchange in a secure and appropriate manner, and
    - facilitating the adoption of appropriate privacy and security frameworks for health care information on behalf of consumers, patients and providers.
- **Indiana Health Information Technology Extension Center (I-HTEC)**
  - Funded through the American Recovery and Reinvestment Act, the Department of Health and Human Services is supporting the development of Regional Extension Centers across the United States to assist providers in adopting and implementing

electronic health records (EHR) to an appropriate level of meaningful use. Purdue University, in conjunction with statewide partners, was awarded funding to establish the Indiana Health Information Technology Extension Center, or I-HITEC, to serve the state of Indiana.

- **Indiana Health Information Exchange (IHIE)**
  - The Indiana Health Information Exchange provides services that streamline the healthcare industry by delivering information at the most critical time: the point-of-care. Their goal is to align transparency, efficiency and quality to improve patient health.
  - IHIE received one of the 17 Beacon Community Program awards. It will serve a broader area that includes the Indiana cities of Anderson, Bloomington, Carmel, Columbus, Fishers, Indianapolis, Kokomo, Logansport, Marion, New Castle, Noblesville, Plainfield, and Richmond.
- **Michiana Health Information Network (MHIN)**
  - The Michiana Health Information Network located in South Bend, Indiana was established in 1999. The network provides electronic result delivery with push technology, interface services for physician practices EHRs and institutional software, its own electronic health record and a series of products supporting clinical registries and health quality improvement. MHIN is dedicated to the improvement of care and the reduction of medical cost in the Michiana community.
- **Midwest Alliance for Telehealth and Technology Resources (MATTeR)**
  - MATTeR supports existing and developing telehealth organizations in meeting the health needs of rural residents and underserved communities. While MATTeR is available to assist on a national basis, the particular focus of MATTeR activities is within the tri-state region of Michigan, Indiana and Kansas.
- **Midwest Alliance for Health Education (MAHE)**
  - MAHE's objective is to provide the energy and imagination that enables linking the resources and activities of a variety of organizations so qualified health care information can be available at the most appropriate time and in the most appropriate format for updating the knowledge of rural health care providers.
  - MAHE received a 2008 Network Planning grant from the US Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy. The lead partners for this initiative are:
    - Midwest Alliance for Telehealth and Technology Resources
    - Marquette General Health System, Marquette, Michigan
    - Clarian Health, Indianapolis, Indianapolis, Indiana
    - Kansas' Area Health Education Centers, University of Kansas Medical Center, Kansas City, Kansas
- **Regenstrief Center for Healthcare Engineering**
  - The role of the Regenstrief Center for Healthcare Engineering (RCHE) at Purdue University is to improve the efficiency, quality and accessibility of healthcare by

tapping into expertise in engineering, science, management and social sciences. Launched in 2005 with a gift from the Regenstrief Foundation, the center is the only integrated university-wide effort in healthcare engineering in the nation.

- As of October 28, 2010, talks with the organizations listed above are still ongoing. We expect many of our healthcare participants to be connected and operational by the end of 2010, and should have more concrete information to report in our next quarterly report.
- As of December 31, 2010, 15 HCPs have been connected to the network. We are in the process of gathering data from our HCPs and should have more concrete information to report in our next quarterly report.

11. Provide detail on how the supported network has complied with HHS health IT initiatives:

a. Explain how the supported network has used health IT systems and products that meet interoperability standards recognized by the HHS Secretary;
b. Explain how the supported network has used health IT products certified by the Certification Commission for Healthcare Information Technology;
c. Explain how the supported network has supported the Nationwide Health Information Network (NHIN) architecture by coordinating activities with organizations performing NHIN trial implementations;
d. Explain how the supported network has used resources available at HHS's Agency for Healthcare Research and Quality (AHRQ) National Resource Center for Health Information Technology;
e. Explain how the selected participant has educated themselves concerning the Pandemic and All Hazards Preparedness Act and coordinated with the HHS Assistant Secretary for Public Response as a resource for telehealth inventory and for the implementation of other preparedness and response initiatives; and
f. Explain how the supported network has used resources available through HHS's Centers for Disease Control and Prevention (CDC) Public Health Information Network (PHIN) to facilitate interoperability with public health and emergency organizations.

- Leadership within the ITN participates on national conference calls and attends industry meetings and webinars to determine the best practices related to HHS health IT initiatives. More information on specific network practices will become available as the network project progresses towards completion.
- In January 2011, the Indiana Health Information Technology, Inc. (IHIT) announced that a funding request from the ONC had been approved to assist many of our Critical Access Hospitals in interfacing with a Health Information Organization (HIO).

- The ITN will continue to work with IHIT and the two Regional Extension Centers in Indiana to assist our HCPs in their efforts to meet meaningful use and adopt EMRs.

12. Explain how the selected participants coordinated in the use of their health care networks with the Department of Health and Human Services (HHS) and, in particular, with its Centers for Disease Control and Prevention (CDC) in instances of national, regional, or local public health emergencies (e.g., pandemics, bioterrorism). In such instances, where feasible, explain how selected participants provided access to their supported networks to HHS, including CDC, and other public health officials.

- While the ITN anticipates full utilization of the network connection for emergencies services agencies, best practices have not yet been determined. More information on specific network practices will become available as the network project progresses towards completion.

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Appendix A

Don Kelso, MBA, ACHE

Donald E. Kelso, MBA, ACHE, is the Executive Director of the Indiana Rural Health Association (IRHA). Previously, Kelso served as Vice President of Operations at Daviess Community Hospital in Washington, Indiana, since October, 1998. Prior to that, he served as Vice President of Human Resources at Daviess Community Hospital from 1994 to 1998 and Director of Human Resources at Jasper Memorial Hospital from 1991 to 1993.

The IRHA is a not-for-profit organization representing a diverse statewide membership consisting of individuals and organizations committed to the improvement of health and resources for rural Hoosiers. The IRHA provides a meaningful forum for assessing the strengths and weaknesses of the health and safety of rural communities, provides educational programs that focus on the unique needs of the residents of rural Indiana and the providers who serve them, and educates the public on relevant issues that bring about the necessary policy changes to ensure that all rural Hoosiers have access to quality health care in their own communities.

Becky Sanders, BA

Rebecca Sanders, BA, is the Network Development Coordinator for the IRHA, and serves as the Associate Project Coordinator for the Indiana Telehealth Network. Previously, she served as the Manager of Tariffs and Training for the National Exchange Carrier Association (NECA) in their Chicago regional offices from 2006 to 2008. Prior to that, she served NECA as the Associate Manager of Tariffs and Training from 2004 to 2006 and as the Associate Manager – Member Services from 2001 to 2004. From 1996 to 2001, she served in various positions at the NECA headquarters offices in Whippany, New Jersey.

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